AMENDED IN ASSEMBLY JULY 6, 2015

AMENDED IN ASSEMBLY JUNE 23, 2015

SENATE BILL No. 388

Introduced by Senator Mitchell

February 25, 2015

An act to amend Section 1363 of the Health and Safety Code, and to amend Section 10603 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 388, as amended, Mitchell. Health care coverage: solicitation and enrollment.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a group health plan and a health insurance issuer offering group or individual health insurance coverage to provide a written summary of benefits and coverage (SBC) and requires that the SBC be provided in a culturally and linguistically appropriate manner, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law requires a plan or insurer to provide certain disclosures of the benefits, services, and terms of a contract or policy. Existing law requires that contracts and policies subject to PPACA satisfy certain of those disclosure requirements by providing the SBC required under PPACA. Existing law requires the departments to adopt regulations establishing standards and requirements to provide enrollees and

insureds with access to language assistance, including requirements for the translation of vital documents, as specified.

This bill would, commencing ~~July 1,~~ *October 1,* 2016, provide that the SBC constitutes a vital document and would require a plan or insurer to comply with requirements applicable to those documents. The bill would, commencing July 1, 2016, require the ~~department~~ *Department of Managed Health Care and the Insurance Commissioner* to develop written translations of the template uniform summary of benefits and coverage and to make available those translations in specified languages on ~~its~~ *their respective* Internet Web ~~site.~~ *sites.* Because a willful violation of those requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following

category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(3) (A) A health care service plan contract subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15), shall satisfy the requirements of this subdivision by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) and any rules or regulations issued thereunder. A health care service plan that issues the uniform summary of benefits referenced in this paragraph shall do both of the following:

(i) Ensure that all applicable benefit disclosure requirements specified in this chapter and in Title 28 of the California Code of Regulations are met in other health plan documents provided to enrollees under the provisions of this chapter.

(ii) Consistent with applicable law, advise applicants and enrollees, in a prominent place in the plan documents referenced

in subdivision (a), that enrollees are not financially responsible in payment of emergency care services, in any amount that the health care service plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in the enrollee's health care service plan contract.

(B) Commencing ~~July 1,~~ *October 1,* 2016, the uniform summary of benefits and coverage referenced in this paragraph shall constitute a vital document for the purposes of Section 1367.04. Not later than July 1, 2016, the department shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the department shall make available on its Internet Web site written translations of the template uniform summary of benefits and coverage developed by the department, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(C) Subdivision (c) shall not apply to a health care service plan contract subject to subparagraph (A).

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available.

Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare Program pursuant to Title XVIII and Title XIX of the federal Social Security Act.

SEC. 2. Section 10603 of the Insurance Code, as amended by Section 8 of Chapter 1 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

10603. (a) (1) On or before April 1, 1975, the commissioner shall promulgate a standard supplemental disclosure form for all disability insurance policies. Upon the appropriate disclosure form as prescribed by the commissioner, each insurer shall provide, in easily understood language and in a uniform, clearly organized manner, as prescribed and required by the commissioner, the summary information about each disability insurance policy offered by the insurer as the commissioner finds is necessary to provide for full and fair disclosure of the provisions of the policy.

(2) On and after January 1, 2014, a disability insurer offering health insurance coverage subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) shall satisfy the requirements of this section and the implementing regulations by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service

Act and any rules or regulations issued thereunder. An insurer that issues the federal uniform summary of benefits referenced in this paragraph shall ensure that all applicable disclosures required in this chapter and its implementing regulations are met in other documents provided to policyholders and insureds. An insurer subject to this paragraph shall provide the uniform summary of benefits and coverage to the commissioner together with the corresponding health insurance policy pursuant to Section 10290.

(3) Commencing ~~July 1,~~ *October 1,* 2016, the uniform summary of benefits and coverage referenced in this subdivision shall constitute a vital document for the purposes of Section 10133.8. Not later than July 1, 2016, the commissioner shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the ~~department~~ *commissioner* shall make available on its Internet Web site written translations of the template uniform summary of benefits and coverage developed by the ~~department,~~ *commissioner,* and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(b) Nothing in this section shall preclude the disclosure form from being included with the evidence of coverage or certificate of coverage or policy.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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